MIPS: How is Ophthalmology Faring and Telehealth in Medicare

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Disclosures

• I have no relevant financial interests or relationships to disclose.
Quality Payment Program (QPP)

- QPP Offers 2 Programs for Reimbursement under Medicare Part B
  - 1) Merit-based Incentive Program System (MIPS)
  - 2) Advanced Alternate Payment Model (APM)

Providers Qualify for Either MIPS or APM
MIPS Payment Adjustments

• Payment
  o Baseline: Standard FFS payments
  o Adjustment two years after measurement:
    ▪ Upward/Neutral/Downward
    ▪ Maximum adjustments (±4%, ±5%, ±7%, ±9%)
    ▪ Partial or full adjustment, based on Final Score
  o MIPS payment adjustments are applied to services provided under Part B

• Budget neutral: Losers$ = Winners$

• Extraordinary performance pool
  o $500M for 5 years (2019-2023)
MIPS 2017 Performance

• Winners tend to participate
• Losers (opt into advanced APMs if they can) – retirees, solos and small, rural
• 4% in penalty avoidance is worth in 2019 about $18,600 per ophthalmologist
  o approximately $186M for ophthalmologists electronically integrated with IRIS.
• Ophthalmology is expected to be among the highest recipients of positive adjustments in 2019 and 2020, but bonuses are/will be low
MIPS Bonuses - 2019

- Maximum 2019 Bonus = 1.88% – if less than exceptional (<70 pts) = 0.20% or less
  - This factor applies to all Part B service claims, but not drugs
  - 71% were exceptional, 22% in small bonus range, 2% neutral, 5% penalized

- Participate to avoid the penalty; not for a large bonus or even the advertised bonus
  - Recall potential bonus was up to 22%
  - Do not overspend to comply
Year 1 (2017) Performance

• 93% of all participants get bonus

• Many scores at nearly 100
  o Median = 89
  o Large groups did well
  o 1 in 5 small practices will be penalized

• This factor will be applied to all service claims, but not Part B drugs in 2019

• 10% of EPs receive 5% APM bonus

• Johns Hopkins Performance (before reset)
  - 2017 Measurement Year Performance
    - Score: 99.99 (of 100)
    - 2019 Payment Adjustment: +2.02%
    - Exceptional Performance Bonus: TBD

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EYE CARE LLC

TIN: #27

FINAL SCORE

100

Payment Adjustment: +1.88%
Exceptional Performance Adjustment: 1.59%
Payment Date: Jan. 1, 2019
MIPS Scores by Size and Location

Navathe et al. Findings And Implications From MIPS Year 1 Performance Data. Health Affairs Blog, January 18, 2019
MedPAC + MIPS = Political Uncertainty

• MedPAC voted 14-2 advising Congress to eliminate MIPS; and

• Establish a “new” voluntary value program (VVP) in FFS Medicare
  o Clinicians can elect to be measured as part of a voluntary group
  o Qualify for value payment based on group performance on population-based measures
  o Payment increases offset by payment decreases (winners and losers)
  o $500MM yearly MIPS exceptional performance bonus funds available ($3B total)
  o Budget-neutral, assuming funds are reinvested in Medicare clinician payment
  o Administrative costs to create voluntary group
  o Reduced clinician reporting burden
  o No impact on access to care
MIPS in the Future

• For performance year two (2018) data submissions are due January 31, 2019
  o Smaller bonuses anticipated in 2020 (per CMS)
    ▪ 93% of ophthalmologists expected to be neutral or positive – 1.4% - among the highest specialties ($82M – $6885 per eligible eyeMD)

• Maximum bonus estimated in year 3 to be higher = 4.7% (about like an APM) (analysis in Health Affairs)

CMS – 5522 –FC
Navathe et al. Findings And Implications From MIPS Year 1 Performance Data. Health Affairs Blog, January 18, 2019
2019 MIPS Performance Scoring

- The MIPS Score is the sum of the weighted Category Scores
  - Score of 30 points required to avoid a penalty
  - Between 30 points and 80 points, clinicians can earn a small bonus
    - MIPS is budget-neutral, so the sum of these bonuses cannot exceed the sum of penalties
  - At or above 80 points, clinicians earn an exceptional performance bonus
MIPS Eligibility

• 2019 Exclusions
  1. Low-Volume Threshold Increased:
     ▪ Clinician bills Medicare Part B no more than $90,000; OR
     ▪ Clinician sees 200 or fewer Medicare patients; OR
     ▪ Clinician has 200 or fewer services
     ▪ But can opt in if exceeds one of the criteria.

  2. New Medicare Provider and APM Participation remain the same.

New classes of providers added (PT, OT, SW, Clin Psych)
## Merit-based Incentive Payment System

### Performance Category Weights

<table>
<thead>
<tr>
<th>Legacy Program</th>
<th>New Category</th>
<th>Score Weight 2017</th>
<th>Score Weight 2018</th>
<th>Score Weight 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQRS</td>
<td>Quality</td>
<td>60%</td>
<td>50%</td>
<td>45%</td>
</tr>
<tr>
<td>MU</td>
<td>Advancing Care Information (ACI) Promoting Interoperability (PI)</td>
<td>25%</td>
<td>25%</td>
<td>25%*</td>
</tr>
<tr>
<td>(None)</td>
<td>Improvement Activities (IA)</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>VBM</td>
<td>Cost</td>
<td>0%</td>
<td>10%</td>
<td>15%</td>
</tr>
</tbody>
</table>
2019 Medicare Physician Payment Final Rule

• Increases coverage of Telehealth services
  o Electronic check in visit
  o Review of patient furnished images
  o Physician to physician consultation
  o More codes eligible for coverage with -95 modifier

• Streamlines documentation requirements

• For 2021 suggestion to collapse EM levels 2-3-4 into a single payment
  o AMA CPT/RUC racing to create the codes for this system
2019 Medicare Rule from CMS

• Change in direction
  o Reinterpret the telehealth regulations in sec 1834(m) of the ACT to allow more telehealth services coverage if those services do not like face to face office visits

• Telehealth – To increase access to communications technology
  o Brief Communication Technology-based Service, e.g. Virtual Check-in (HCPCS code G2012) (~$13)
  o Remote Evaluation of Recorded Video and/or Images Submitted by the Patient (HCPCS code G2010) (~$15)
  o Internet Consultation (CPT codes 99451 ($37), 99452, 99446 ($18), 99447 ($38), 99448, and 99449 ($73)
Diabetic Vision Loss and Blindness Prevention Act (H.R. 6639)

•Introduced by Reps. Tom Reed (R-NY) and Terri Sewell (D-AL) in July 2018
•Goal is to expand access to digital retinal imaging with remote interpretation under the Medicare program – which Academy supports
•Legislation would have mandated the use of a specific CPT code, 92250
  o 92250 developed for an office-based procedure that involves additional physician work/direct interaction between the physician and patient
  o CPT codes (92227 or 92228) developed for instances when imaging is done at one site and readings are performed by a provider at a different location
•No companion bill in Senate
•No action taken in the 115th Congress/Work with sponsors on alternative approach for 116th Congress
Screenings for Eye Evaluation, Monitoring, Observation, Review, and Examination (SEE MORE) Act (S. 3751)

• Introduced by Sen. Bob Casey (D-PA) and Sen. Chuck Grassley (R-IA) in December 2018

• Goal to expand the use of telehealth services for remote imaging for chronic eye disease:
  - Lifts existing Medicare originating site requirements on telehealth services;
  - Applies to FDA-approved ocular imaging techniques and technologies, including artificial intelligence technologies; and
  - Requires a report to Congress after 5 years on the utilization of these services, health outcomes, and specialty referral rates

• No companion bill in House

• No action taken in 115th Congress/Expect reintroduction in 116th Congress